

# Medicare Advantage Private Fee-for-Service Plans: What Privatization Means for Today's Beneficiaries

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# MEDICARE ADVANTAGE PRIVATE FEE-FOR-SERVICE PLANS: WHAT PRIVATIZATION MEANS FOR TODAY'S BENEFICIARIES

Melissa M. Ostrowski\*

## INTRODUCTION

Health care compensation in the United States involves a system of privatization that is unique among industrial countries in that third-party insurers pay health care providers for care given to the insured.<sup>1</sup> Through the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Modernization Act), Congress incorporated privatization into Medicare, a federal health program that was designed to be completely administered by the government.<sup>2</sup> The Modernization Act created a system of managed competition between private insurers and the government.<sup>3</sup> Today, as a result, Medicare beneficiaries have more privatized health care options than ever before.

One coverage option available to Medicare beneficiaries under the Modernization Act is the Private Fee-For-Service

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1. BARRY R. FURROW ET AL., *HEALTH LAW: CASES, MATERIALS AND PROBLEMS* 566 (5th ed. 2004).

2. MARSHA GOLD, HENRY J. KAISER FAMILY FOUND., *THE MEDICARE RX DRUG LAW: THE GROWTH OF PRIVATE PLANS IN MEDICARE iv* (2006), <http://www.kff.org/medicare/upload/7473.pdf> (last visited Mar. 21, 2007) [hereinafter *THE MEDICARE RX DRUG LAW*].

3. *Id.*

(PFFS) plan.<sup>4</sup> Many of the PFFS plans offer beneficiaries lower out-of-pocket costs and benefits not offered under traditional Medicare.<sup>5</sup> This article discusses the development of privatized Medicare plans and how Medicare Advantage (MA) PFFS plans function. It then assesses the current expansion and growth of PFFS plans, as well as their costs, criticism, and long-term viability. Finally, this article compares the costs and coverage of traditional Medicare to two PFFS plans available to beneficiaries at no additional premium cost above the Part B premium.

### DEVELOPMENT OF PRIVATE MEDICARE PLANS

In 1972, Congress enacted Public Law 92-603 in its first attempt to incorporate privatized insurance into Medicare by allowing beneficiaries to enroll in Medicare-approved HMO plans.<sup>6</sup> Few Medicare beneficiaries and HMOs participated in this initial scheme.<sup>7</sup> Then in 1982, Congress enacted the Tax Equity and Fiscal Responsibility Act (TEFRA) to expand HMO-provided managed care in Medicare.<sup>8</sup> Medicare HMO plans offered the same coverage for treatment of ailments and conditions as traditional Medicare, but frequently included additional coverage for preventative health care and screenings.<sup>9</sup> Some HMO plans also paid for routine physicals, immunizations, vision care, and dental care.<sup>10</sup> Many Medicare beneficiaries were attracted to the additional benefits, thus Medicare HMO enrollment reached 1 million by 1987 and 5.2 million by 1997.<sup>11</sup>

In response to the success of Medicare HMOs under TEFRA and escalating expenditures,

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4. *See id.*

5. *See id.*

6. AMERICAN ASSOCIATION OF HEALTH PLANS, THE MEDICARE + CHOICE PROGRAM: WHAT YOU NEED TO KNOW 2 (May 2002), [http://www.aahp.org/Content/ContentGroups/Reports\\_Fact\\_Sheets/MCH52002.pdf](http://www.aahp.org/Content/ContentGroups/Reports_Fact_Sheets/MCH52002.pdf) (last visited Mar. 21, 2007).

7. *Id.*

8. *Id.*

9. *Id.*

10. *Id.*

11. *Id.* at 2-3.

Congress enacted the Balanced Budget Act of 1997 (BBA), creating the Medicare + Choice program.<sup>12</sup> Medicare + Choice was intended not only to expand the availability of HMOs and other managed care plans, but also to promote managed competition among plans in order to control costs and give beneficiaries additional plan options.<sup>13</sup> Under Medicare + Choice, beneficiaries could select plans in a variety of coverage forms, including plans by preferred provider organizations (PPOs), provider-sponsored organizations (PSOs), private fee-for-service (PFFS) plans, and medical savings accounts (MSAs), provided these plans were available in the beneficiaries' geographic areas of residency.<sup>14</sup>

Soon after Medicare + Choice was enacted, HMOs and other plan providers gradually began withdrawing from their contracts,<sup>15</sup> and Medicare + Choice became under-funded. Payments to private plans did not increase as rapidly because of changes to payment structure and a slow-down in traditional Medicare spending.<sup>16</sup> Many of the approved plans withdrew from the market, and the plans that remained reduced the number and size of service areas, cut benefits, and increased premiums.<sup>17</sup> As a result, beneficiary enrollment dropped dramatically. "Between 1999 and 2003, the number of enrollees declined from 6.3 million to 4.6 million."<sup>18</sup>

As private plans withdrew from Medicare + Choice, the overall federal Medicare expenditures steadily increased.<sup>19</sup> In 2004, Medicare expenditures reached \$295 billion, which

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12. HENRY J. KAISER FAMILY FOUND., FACT SHEET: MEDICARE ADVANTAGE 1 (2005), <http://www.kff.org/medicare/upload/Medicare-Advantage-April-2005-Fact-Sheet.pdf> (last visited Mar. 21, 2007) [hereinafter FACT SHEET].

13. FURROW, *supra* note 1, at 754.

14. FACT SHEET, *supra* note 12, at 1.

15. LAWRENCE A. FROLIK & ALISON MCCHRISTAL BARNES, ELDER LAW CASES AND MATERIALS 232 (3d ed. 2003).

16. THE MEDICARE RX DRUG LAW, *supra* note 2, at iv.

17. *Id.*

18. *Id.*

19. See HENRY J. KAISER FAMILY FOUND., MEDICARE CHART BOOK 53 FIG.6.1 (2005), <http://www.kff.org/medicare/7284.cfm> (last visited Mar. 21, 2007) [hereinafter MEDICARE CHART BOOK].

amounted to 17% of the total national health expenditures and 12% of the federal budget.<sup>20</sup> At that point, Congress also recognized that the Medicare program faced an imminent strain on funding with the retirement of the baby-boomer generation, when more elderly people would require health services while fewer workers would be contributing to the Medicare trust funds.<sup>21</sup>

In response to the increased government expenditures and to the impending collapse of Medicare + Choice, Congress passed the Modernization Act,<sup>22</sup> wherein a new program, Medicare Advantage (MA), was created.<sup>23</sup> MA essentially reformulated Medicare + Choice by expanding managed care and establishing a system of managed competition between private insurers and the government.<sup>24</sup> MA also created new plan types, including regional PPOs, "special needs plans," and new Part D private drug plans.<sup>25</sup>

Under MA, beneficiaries have more private plan options available to them than ever before.<sup>26</sup> In 2006, all Medicare beneficiaries nationwide have one or more MA plan option available to them.<sup>27</sup> This growth in plan participation and geographic availability is primarily attributed to the growth of PFFS plans.<sup>28</sup>

### MEDICARE ADVANTAGE PRIVATE FEE-FOR-SERVICE PLANS

Private Fee-For-Service (PFFS) plans are one of several private plan options available to Medicare beneficiaries under MA.<sup>29</sup>

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20. *Id.* at 54 figs.6.3-4.

21. *See id.* at 64 fig.7.6.

22. *See* Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 (codified at 42 U.S.C.A §§ 1395w-101 to -152).

23. THE MEDICARE RX DRUG LAW, *supra* note 2, at iv.

24. *Id.*

25. FACT SHEET, *supra* note 12, at 1.

26. THE MEDICARE RX DRUG LAW, *supra* note 2, at iv.

27. *Id.* at 10, tbl. 2.

28. *Id.* at 9.

29. *Id.* at 10, tbl. 2.

Private insurers create PFFS plans and offer them to beneficiaries in place of traditional Medicare coverage.<sup>30</sup> PFFS plans are available in areas selected by the PFFS plan insurers.

The Centers for Medicare and Medicaid Services (CMS) requires private insurers to follow specific procedures in order to offer PFFS plans under MA.<sup>31</sup> All PFFS plans must submit an application for participation, which must be approved by CMS.<sup>32</sup> The insurer must specify the determined plan coverage area, whether the plan will offer additional services not normally covered by Medicare, and what deductibles or charges enrollees will have to pay.<sup>33</sup>

Once CMS approves of PFFS plans, CMS reimburses the insurers for arranging and paying for health coverage of enrolled Medicare beneficiaries.<sup>34</sup> CMS pays the insurers a set amount each month to provide coverage to enrolled Medicare eligibles on a fee-for-service basis.<sup>35</sup> This reimbursement is comprised of risk-based monthly capitated payments based on each beneficiary's county of residence and the costs of traditional Medicare in that county.<sup>36</sup> There are also floor payments for both rural and urban counties, phased-in risk adjustments, and formulas to update payments from year to year.<sup>37</sup> Payments are also adjusted to include an element of competitive bidding.<sup>38</sup> The rates derived from the policy of floor payments, risk adjustments, and formulas serve as benchmarks

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30. CTR. FOR MEDICARE & MEDICAID SERV., YOUR GUIDE TO PRIVATE FEE-FOR-SERVICE PLANS 1 (2006), <http://www.medicare.gov/Publications/Pubs/pdf/10144.pdf> (last visited Mar. 24, 2007) hereinafter YOUR GUIDE TO PFFS PLANS].

31. See MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO THE CONGRESS: ISSUES IN A MODERNIZED MEDICARE PROGRAM, CHAPTER 3: THE MEDICARE ADVANTAGE PROGRAM 59, 74 (June 2005), [http://www.medpac.gov/publications/congressional\\_reports/June05\\_Entire\\_report.pdf](http://www.medpac.gov/publications/congressional_reports/June05_Entire_report.pdf) (last visited Mar. 24, 2007).

32. *Id.* at 74.

33. *Id.*

34. See *id.*

35. YOUR GUIDE TO PFFS PLANS, *supra* note 30, at 1.

36. THE MEDICARE RX DRUG LAW, *supra* note 2, at 6.

37. *Id.* at 7.

38. *Id.*

for bid evaluation.<sup>39</sup> The payment system is designed to ultimately encourage private insurer participation.<sup>40</sup>

Medicare beneficiaries who choose to enroll in PFFS plans are still considered enrolled in Medicare, and they still have Medicare rights, protections, and the equivalent of Medicare Part A and Part B coverage.<sup>41</sup> To participate in a PFFS plan, beneficiaries must enroll in the plan and meet specific criteria.<sup>42</sup> A beneficiary who wants to enroll in a PFFS plan must: (1) have Medicare Parts A and B coverage; (2) live in a plan service area; and (3) pay the monthly Part B premium, along with any additional, monthly PFFS plan premiums, plan charges, deductibles, coinsurance payments, or co-payments.<sup>43</sup>

Medicare beneficiaries can learn about PFFS plan coverage and availability in several ways. First, literature and online brochures from CMS allows Medicare beneficiaries to access information about PFFS plans and their geographic availability.<sup>44</sup> Beneficiaries can compare the coverage and costs of different PFFS plans to traditional Medicare and other MA plan forms on the CMS website.<sup>45</sup> Insurers also have corporate websites and company benefit summaries that detail plan availability and coverage.<sup>46</sup> Beneficiaries may not have to actively seek out this information, as it is becoming more common for PFFS insurers to use traveling outreach initiatives to market their plans.<sup>47</sup>

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39. *Id.*

40. *See id.*

41. CTR. FOR MEDICARE & MEDICAID SERV., MEDICARE AND YOU 35 (2007), <http://www.medicare.gov/publications/pubs/pdf/10050.pdf> (last visited Mar. 21, 2007) [hereinafter MEDICARE AND YOU].

42. *See id.* at 34.

43. CTR. FOR MEDICARE & MEDICAID SERV., PRIVATE FEE-FOR-SERVICE - BENEFICIARY QUESTIONS AND ANSWERS 8-9 (Feb. 2006), <http://www.cms.hhs.gov/PrivateFeeForServicePlans/Downloads/benqa.pdf> (last visited Mar. 21, 2007) [hereinafter BENEFICIARY QUESTIONS AND ANSWERS].

44. *See e.g.*, MEDICARE AND YOU, *supra* note 41, at 34-36.

45. *Id.* at 36-37.

46. *See* Anthem Blue Cross and Blue Shield, *SmartValue Wisconsin, Summary of Benefits and Other Value-Added Services: January 1, 2007 - December 31, 2007* (2006); *see also* Humana, *Humana Gold Choice PFFS, 2007 Summary of Benefits* (2006).

47. *See* Cross-Country Caravan Sets Out Again to Educate Consumers about Medicare, MANAGED CARE WEEKLY DIGEST, Sept. 18, 2006, at 11.

However, before beneficiaries enroll, they should not only be familiar with the PFFS plan coverage and costs, but they should also confirm that their care providers accept payments from the PFFS plans they are considering.<sup>48</sup> Once a beneficiary decides to enroll in a particular PFFS plan, he or she must apply to the private insurer directly by completing an enrollment form.<sup>49</sup>

Beneficiaries should be aware that PFFS plans differ from MA managed care plans, including HMOs and PPOs.<sup>50</sup> First, beneficiaries with PFFS plans are not restricted to a network of providers and they do not need to obtain a referral from a primary care provider in order to receive care from specialists.<sup>51</sup> PFFS beneficiaries may select their providers as long as the providers are willing to accept payments from the PFFS plan.<sup>52</sup> Also, PFFS plans are available to beneficiaries in more geographic areas than some other MA plans.<sup>53</sup> In 2006, eighty percent of all Medicare beneficiaries could enroll in a PFFS plan; while eighty-eight percent had access to regional PPO plans, only seventy-eight percent had access to local HMO or PPO plans.<sup>54</sup> However, one disadvantage that PFFS plans have when compared to MA managed care plans is they may offer fewer preventative services.<sup>55</sup>

### THE SUCCESS OF PFFS PLANS

PFFS plans are attractive to beneficiaries, and, as a result, the participation of both PFFS plan insurers and beneficiaries has steadily increased.<sup>56</sup> Medicare beneficiaries are attracted by

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48. MEDICARE AND YOU, *supra* note 41, at 36.

49. YOUR GUIDE TO PFFS PLANS, *supra* note 30, at 8.

50. See BENEFICIARY QUESTIONS AND ANSWERS, *supra* note 43, at 11.

51. *Id.*

52. THE MEDICARE RX DRUG LAW, *supra* note 2, at 6.

53. *Id.* at 9-10, tbl. 2.

54. *Id.* at 10, tbl. 2.

55. BENEFICIARY QUESTIONS AND ANSWERS, *supra* note 43, at 16.

56. See STEPHANIE PETERSON & MARSHA GOLD, HENRY J. KAISER FAMILY FOUND., TRACKING MEDICARE HEALTH AND PRESCRIPTION DRUG PLANS: MONTHLY REPORT FOR AUGUST 2006 1 (SEPT. 2006) <http://www.kff.org/medicare/upload/medicaretracking0806.pdf> (last visited Mar. 21, 2007) [hereinafter TRACKING MEDICARE].



the additional benefits, lower out-of-pocket expenses, and less speculative costs that PFFS plans offer, as compared with traditional Medicare.<sup>57</sup> In August 2006, there were 802,068 Medicare beneficiaries enrolled in PFFS plans, which was an increase of 38,509 enrollees since July 2006.<sup>58</sup> From August 2005 to August 2006, 682,345 additional Medicare beneficiaries enrolled in PFFS plans.<sup>59</sup>

The popularity of PFFS plans among beneficiaries has led more private insurers to enter the PFFS plan market, and, as a result, more beneficiaries have plans available in their area.<sup>60</sup> As of August 2006, there were twenty-five MA PFFS plans, up from sixteen available plans in August 2005.<sup>61</sup> Four hundred and twenty-six MA plans have been approved for the year 2007.<sup>62</sup> Because PFFS plans do not need to establish provider networks like HMOs and other MA plans, PFFS plans "require less effort to establish and present fewer challenges for their sponsors."<sup>63</sup> Consequently, seventy-nine percent of urban area beneficiaries and ninety-seven percent of rural beneficiaries have PFFS plans available to them in their area.<sup>64</sup>

PFFS plans have faced criticism, despite their success since MA was passed in 2003. Unlike other MA plans, PFFS plans directly compete with traditional Medicare, which itself is a fee-for-service system.<sup>65</sup> Some critics argue that the competition from PFFS plans unfairly burdens traditional Medicare.<sup>66</sup> Traditional Medicare has to compete against PFFS plans while remaining within the confines of statutory requirements that

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57. See Freudenheim, *Fee-for-Service Health Plans Flourish With Government Help*, N.Y. TIMES, Sept. 22, 2006, at C1.

58. TRACKING MEDICARE, *supra* note 56, at 1.

59. *Id.*

60. *See id.*

61. *Id.* at 2.

62. Laura B. Benko, *Many Happy Returns: Insurers Flock Back to the Medicare Managed-Care Market, But How Long Will They Stick Around This Time?*, MODERN HEALTHCARE, Oct. 30, 2006, at 24.

63. THE MEDICARE RX DRUG LAW, *supra* note 2, at 9.

64. *Id.*

65. Freudenheim, *supra* note 57, at C1.

66. FURROW, *supra* note 1, at 761.

PFFS plans do not have, including the requirement to cover indirect medical education costs.<sup>67</sup> As a result, traditional Medicare may be forced to increase Part B premiums in order to compete.<sup>68</sup> Congressional Democrats have also criticized CMS for showing bias in favor of MA plans over traditional Medicare.<sup>69</sup>

The federal government's current practice of paying an eleven percent subsidy per beneficiary to PFFS plans is also criticized.<sup>70</sup> Depending on local care costs and the health of the individual beneficiaries, a monthly federal subsidy to the insurance company per beneficiary can range from \$400 to \$2500.<sup>71</sup> Administering the Medicare program is costly; in 2004, administrative expenses accounted for 1.9% of the Medicare benefit payments.<sup>72</sup> As a consequence, some critics believe that by paying the eleven percent subsidy, the federal government is essentially paying private insurers "to take Medicare off its hands."<sup>73</sup>

Defenders of PFFS plans have justified the subsidies by asserting that privatization will lower the high administrative costs of traditional Medicare; however, critics are unconvinced that paying subsidies to private insurers will save any money in the future.<sup>74</sup> Thus far, MA has not lowered overall Medicare expenditures, and no decrease in expenditures is within sight.<sup>75</sup> In fact, since MA was enacted, CMS expenditures to private plans have proven to cost CMS more than it would for CMS to provide the beneficiaries with traditional Medicare coverage.<sup>76</sup>

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67. *Id.*

68. *Id.*

69. See Robert Pear, *Democrats Critical of New Medicare Guide*, N.Y. TIMES, Oct. 30, 2006, at A16.

70. Freudenheim, *supra* note 57, at C1.

71. *Id.*

72. MEDICARE CHART BOOK, *supra* note 19, at 58.

73. *Id.*

74. Freudenheim, *supra* note 57, at C1.

75. See *id.*

76. *Id.*

*ARE PFFS PLANS VIABLE IN THE LONG RUN?*

Thus far, private insurers have been encouraged to develop and offer MA PFFS plans, both by the federal subsidies and the current destabilization of the private insurance market.<sup>77</sup> In 2006, Medicare will pay \$7 billion to PFFS plan insurers, which is at least \$770 million more than what it would cost CMS to provide the coverage.<sup>78</sup> Federal expenditures to PFFS plan insurers are expected to increase as analysts predict that PFFS plan participation will double, and perhaps even triple, by the year 2009.<sup>79</sup>

Although PFFS plans have grown in availability and popularity, critics cast doubt on whether they are sustainable for the long-term. First, the viability of PFFS plans hinges on the continuation of the federal subsidies and on the overall profitability of the market.<sup>80</sup> Insurers are now jumping into the PFFS plan market because they are "getting while the getting's good."<sup>81</sup> The failings of Medicare + Choice demonstrated how fragile privatized Medicare can be, and that insurers will leave the market once it is no longer profitable for them.<sup>82</sup> Congressional cutbacks to Medicare funding could destabilize the PFFS plan market.<sup>83</sup> Members of Congress have already voiced criticism of the increased expenditures and subsidies; continuation of the funding relies on the stability of the economy and the nature of the political climate.<sup>84</sup> Because PFFS plans do not require insurers to establish a provider network, insurers could drop plan coverage easily if Congress discontinued the subsidies or reduced reimbursement.<sup>85</sup>

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77. *Id.*

78. *Id.*

79. *Id.*

80. Benko, *supra* note 62, at 24.

81. *Id.*

82. *Id.*

83. *Id.*; see also Freudenheim, *supra* note 57, at C1.

84. Benko, *supra* note 62, at 24.

85. *Id.*

The success of PFFS plans also relies on health care providers accepting PFFS payments. When providers refuse PFFS payments, insurers often choose not to provide coverage in those areas, and beneficiaries cannot enroll in those plans.<sup>86</sup> Some health care providers within PFFS plan areas have already chosen not to accept PFFS plan payments, leaving enrolled beneficiaries without care coverage by their providers.<sup>87</sup> In some rural areas, such as those in New Mexico, PFFS plans have not been able to enroll enough beneficiaries to encourage provider acceptance of payments.<sup>88</sup> If Medicare eligibles enroll in PFFS plans without first checking with their providers, and then they discover that their providers will not accept payments, they often incur great out-of-pocket costs as a result.<sup>89</sup> Many Medicare beneficiaries are already bombarded with confusing solicitations to enroll in Medicare Part C and D plans, so if they enroll in a PFFS plan and then discover they cannot receive care from their providers, they may become leery of all privatized plans. Likewise, beneficiaries who otherwise would enroll in PFFS plans may choose not to if stories of coverage gaps are publicized.

Also, current gaps in the availability of PFFS plans may endanger PFFS plan viability. PFFS plans are more available to beneficiaries in rural areas and small towns that have fewer provider options.<sup>90</sup> When Medicare increased the subsidies to PFFS plans in 2003, insurers had an incentive to establish plans in rural areas because once enough patients enrolled in an area, local providers had little choice but accept the payments.<sup>91</sup> There are also state variances and gaps, as some states have low overall percentages of Medicare beneficiaries with PFFS plans

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86. *See id.*

87. Julie Anderson, *Creighton Doctors Say No to Private Medicare Plans*, OMAHA WORLD-HERALD, Oct. 14, 2006.

88. Diana Heil, *Seniors Should Take Care When Signing Up for Medicare Plans*, THE SANTA FE NEW MEXICAN at D-1 through D-2, Feb. 11, 2006.

89. *See id.*

90. Freudenheim, *supra* note 57, at C1.

91. *Id.*

available to them, including Maryland with four percent, Connecticut with ten percent, and California with twenty-five percent.<sup>92</sup>

Consequently, long-term viability of PFFS plans remains unclear because of the various contingencies, including continuation of congressional funding and subsidies, the acceptance of payments by health care providers, and the maintenance of adequate geographic coverage areas.<sup>93</sup> PFFS plan insurers and health care providers' participation depends heavily on the stability of the market. The stability of PFFS plans is also contingent on beneficiary enrollment.<sup>94</sup> PFFS plans have yet to overcome the historic preference of beneficiaries for traditional Medicare, and it remains to be seen whether PFFS plans have the capability to change that preference.<sup>95</sup>

#### **ARE PRIVATE FEE-FOR-SERVICE PLANS A BETTER CHOICE FOR MEDICARE BENEFICIARIES THAN TRADITIONAL MEDICARE?**

Two popular PFFS plans are available to beneficiaries for no cost above the Medicare Part B deductible. The costs and coverage of these two plans can be compared to traditional Medicare costs and coverage, as shown in Table 1.

#### **TRADITIONAL MEDICARE COVERAGE**

Traditional Medicare is a fee-for-service health plan managed by the federal government which is comprised of Part A inpatient hospital coverage, optional Part B supplemental medical insurance, and optional Part D prescription drug coverage.<sup>96</sup> Part A covers some of the costs of medically necessary hospital stays, skilled nursing facility care, home

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92. THE MEDICARE RX DRUG LAW, *supra* note 2, at 11, tbl. 3; 13, tbl. 3.

93. See Benko, *supra* note 62, at 24; see also Freudenheim, *supra* note 57, at C1.

94. THE MEDICARE RX DRUG LAW, *supra* note 2, at vi.

95. See *id.*

96. MEDICARE AND YOU, *supra* note 41, at ii, 25.

health care, hospice care, and blood work.<sup>97</sup> To be eligible for Part A, an individual must either (1) be over age sixty-five and have paid FICA or SECA taxes for a minimum of forty quarters; (2) be disabled for a minimum of twenty-four months; (3) have end-stage renal disease requiring dialysis or kidney transplant; or (4) be over sixty-five, but ineligible for Social Security because he or she has not worked the minimum number of quarters, but who elects to buy Part A coverage for a monthly premium.<sup>98</sup>

Individuals who are eligible for Part A are generally eligible for Part B, but must pay a premium.<sup>99</sup> Part B coverage helps pay for medically necessary services and preventative care not covered under Part A.<sup>100</sup> Part B also helps enrolled beneficiaries cover the costs of physician services, outpatient hospital services, clinical lab services and tests, screenings, diagnostic services, dialysis, diabetic supplies, durable medical equipment, blood, telemedicine, and home health services.<sup>101</sup>

Under traditional fee-for-service Medicare, a beneficiary enrolled in Part A and Part B must pay, at a minimum, monthly premiums and the deductible.<sup>102</sup> In 2007, Part B premiums vary according to the income of the beneficiary.<sup>103</sup> If a beneficiary makes less than \$80,000 in 2007, he or she will pay the basic premium of \$93.50.<sup>104</sup> However, if a beneficiary earns more than the base premium amount of \$80,000, he or she must pay a higher premium, which varies according to earnings.<sup>105</sup> Part B beneficiaries also must pay a deductible of \$131 in 2007.<sup>106</sup>

Under Part A, beneficiaries must pay inpatient care costs

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97. *Id.* at 9.

98. FROLIK & BARNES, *supra* note 15, at 222.

99. *Id.* at 223.

100. *Id.* at 224.

101. *Id.* at 224, 226.

102. CTR. FOR MEDICARE & MEDICAID SERV., MEDICARE OPTIONS COMPARE (2007), <http://www.medicare.gov/MPPF/Include/DataSection/Questions/SearchOptions.asp> (last visited Mar. 21, 2007) [hereinafter MEDICARE OPTIONS COMPARE].

103. MEDICARE AND YOU, *supra* note 41, at 11.

104. *Id.*

105. *Id.*

106. MEDICARE OPTIONS COMPARE, *supra* note 102.

that vary according to the length of stay.<sup>107</sup> In 2007, a beneficiary must pay a \$992 deductible for days 1-60, \$248 per day for days 61-90, and \$496 per lifetime reserve day for days 91-150.<sup>108</sup> In a skilled nursing facility, there are no costs for days 1-20, \$119 per day for days 21-100, and beneficiaries pay all costs after day 100.<sup>109</sup>

Medicare also requires enrolled beneficiaries to pay twenty percent coinsurance for doctor office visits, ambulance services, durable medical equipment, diagnostic tests, and x-rays.<sup>110</sup> For outpatient hospital services, the beneficiary must pay coinsurance that varies by service and twenty percent coinsurance for medical and other services.<sup>111</sup>

According to CMS Medicare Options Compare, traditional Medicare annually costs the average beneficiary age 65-69 \$3200 if in very good health; \$4100 if in good health; \$5900 if in fair health; and \$9000 if in poor health.<sup>112</sup>

Consider the hypothetical scenario of Alma Average, a sixty-seven year old Medicare beneficiary in good health. Since Alma's husband died several years ago, her primary income is Social Security benefits, which amounts to less than \$80,000 each year. According to her income level, Alma pays the Part B premium of \$93.50 per month, and if she does not require any health services, she faces an annual cost of only \$1122 per year.

However, Alma slipped and fell in her home, and was admitted to the local hospital with a broken leg and head trauma. The hospital discharged Alma on day 40, for which she paid a \$992 deductible, totaling her yearly cost to \$2114. One week later, she had trouble breathing and was re-admitted to the hospital for pneumonia. Since she was still within the first 60 days, or the "spell of illness," she would pay \$248 per day for days 61-90. Alma was very sick and stayed 33 days, up to day

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107. *Id.*

108. *Id.*

109. MEDICARE AND YOU, *supra* note 41, at 102.

110. *Id.* at 102-03.

111. *Id.* at 103.

112. MEDICARE OPTIONS COMPARE, *supra* note 102.

80. This second episode cost her \$4960, totaling her yearly cost to \$7074. She visited her doctor once after this, which cost her the \$131 Part B deductible plus \$13.80, 20% of the remainder of the doctor's \$200 fee. Alma also needed a \$300 walker, which cost her \$60 or 20% of the walker's cost. Now, Alma's costs total to \$7278.80.

Alma's scenario demonstrates that under traditional Medicare out-of-pocket costs are significant with a hospital stay over sixty days. Alma did not have a stay over ninety days, which would have caused costs to skyrocket. What Alma would want to avoid under traditional Medicare is a hospital stay between 91-150 days, because those days are "reserve days," which cost \$496 per day and are available to her only once in her lifetime. Alma also wants to avoid any stay over 150 days because then she must pay all costs.

Traditional Medicare charges Alma a percentage of the costs, usually twenty percent, for most Part B benefits. However, Alma may not know what the total cost will be, thus she can only speculate as to which costs she will be responsible.

**FIRST PFFS ALTERNATIVE - SMARTVALUE CLASSIC BY  
ANTHEM/BLEU CROSS-BLEU SHIELD**

SmartValue Classic, offered by Anthem/Blue Cross-Blue Shield, is a MA PFFS plan available to Wisconsin Medicare beneficiaries in 2007.<sup>113</sup> Any Medicare beneficiary entitled to Medicare Part A and enrolled in Part B can enroll in SmartValue Classic, except for those with end-stage renal disease.<sup>114</sup> Beneficiaries still pay the Medicare Part B premium, but do not pay another premium while obtaining additional benefits and coverage.<sup>115</sup> Beneficiaries can select any doctor or provider that accepts payment from the plan.<sup>116</sup>

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113. See Anthem Blue Cross and Blue Shield, *supra* note 46, at i.

114. *Id.* at 1.

115. See *id.* at 3.

116. *Id.*



SmartValue Classic offers coverage for services not covered under traditional Medicare. Beneficiaries may receive one pair of eyeglasses or contact lenses, up to seventy-five dollars in value, every two years, and fifty percent of the cost of a routine eye exam each year.<sup>117</sup> Beneficiaries may also have one physical exam per year at a ten-dollar co-payment cost.<sup>118</sup>

SmartValue Classic is unlike traditional Medicare in its payment of inpatient care. First, a beneficiary must notify SmartValue Classic of planned admissions, or he or she will have to pay an additional \$50 per day, up to \$500 per admission.<sup>119</sup> With proper notification, a beneficiary pays \$150 a day for days 1-5.<sup>120</sup> SmartValue Classic does not have a co-payment for additional days beyond the first five days, because there is a maximum out-of-pocket limit of \$750, per year, for hospital coverage.<sup>121</sup> There are no costs to the beneficiary after paying for the first five days.<sup>122</sup>

SmartValue Classic also differs from traditional Medicare in its coverage of care within skilled nursing facilities.<sup>123</sup> Like traditional Medicare, there are no costs for days 1-20; however, instead of \$119 per day for days 21-100, SmartValue costs \$25 per day for days 21-100.<sup>124</sup>

SmartValue Classic's outpatient coverage varies from traditional Medicare coverage as follows:

- 1) Doctor Office Visits: Beneficiaries pay \$10 for primary care doctor or specialist visits. Traditional Medicare requires beneficiaries to pay 20% of the cost of each visit.<sup>125</sup>
- 2) Outpatient Surgeries and Services: Instead of paying 20% of the facility charges and doctor charges like under

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117. *Id.* at 25.

118. *Id.* at 26.

119. *Id.* at 4.

120. *Id.*

121. *Id.*

122. *Id.*

123. *See id.* at 6.

124. *Id.*

125. *Id.* at 8.

Medicare, beneficiaries pay \$100 to an ambulatory surgical facility and \$10 to \$100 to an outpatient hospital facility.<sup>126</sup>

- 3) Emergency Care and Urgently-Needed Care: Beneficiaries pay \$50 for each visit if not admitted within 72 hours for the same condition, and coverage is worldwide. Under Medicare there is no coverage outside of the U.S., and beneficiaries pay 20% of the doctor charges and the facility charge or a co-payment for each visit if not admitted within three days for the condition.<sup>127</sup>
- 4) Outpatient Rehabilitation: Beneficiaries pay \$10 per visit, instead of 20% of Medicare-approved amounts.<sup>128</sup>
- 5) Durable Medical Equipment and Prosthetics: Beneficiaries pay 30% of the cost for each item, and if they fail to notify the plan of a purchase over \$750, they must pay 70%. Traditional Medicare requires beneficiaries to pay 20% of the cost for each item.<sup>129</sup>
- 6) Diagnostic Tests, Lab Services, and X-Rays: Beneficiaries pay \$0 to \$25 for each test, service, or x-ray. Under traditional Medicare, beneficiaries do not have a co-payment for approved lab services, but pay 20% for all other services.<sup>130</sup>
- 7) Preventative Services: Unlike traditional Medicare which requires co-payments with few exceptions, there are no co-payments for immunizations, colorectal screenings, bone mass screenings, mammograms, or pelvic exams.<sup>131</sup>

According to CMS Medicare Options Compare, SmartValue Classic annually costs the average beneficiary age 65-69: \$2800 if

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126. *Id.* at 10.

127. *Id.* at 11-12.

128. *Id.* at 12.

129. *Id.* at 13.

130. *Id.* at 14.

131. *Id.* at 15-16.

in very good health (Traditional Medicare, \$3200); \$3550 if in good health (Traditional Medicare, \$4100); \$4500 if in fair health (Traditional Medicare, \$5900); and \$7350 if in poor health (Traditional Medicare, \$9000).<sup>132</sup>

Again, consider the hypothetical scenario of Alma Average, who now has elected to participate in the SmartValue Classic PFFS plan available. Because her income is less than \$80,000, she pays the Part B premium of \$93.50 per month, and if she does not require any health services, she faces an annual cost of only \$1122 per year.

However, Alma was admitted to the local hospital after breaking her leg and suffering head trauma and discharged at day 40. If she notified Anthem of her admittance and the hospital accepts SmartValue Classic payments, she only has to pay \$750, the cost of five days. This brings her yearly cost to \$1872 after her 40-day stay, which is \$242 less than what she would pay under traditional Medicare. When Alma was re-admitted for pneumonia one week later and stayed for an additional 33 days, she did not incur additional costs. Consequently, at the end of her second episode, her yearly costs are the same as before she entered at \$1872, compared with \$7074 under traditional Medicare.

For Alma to see her doctor for a follow-up, she must pay a \$10 co-payment, as opposed to \$40, or 20% of the \$200 fee under traditional Medicare. She also needed a \$300 walker so she had to pay \$90, or 30% of its cost, compared with \$60 under traditional Medicare. Under this scenario, Alma's yearly costs under the Anthem SmartValue Classic plan total \$1972, compared to \$7278.80 under traditional Medicare.

Alma Average's hypothetical situation shows the strengths of the SmartValue Classic PFFS plan. First, out-of-pocket costs are significantly less than under traditional Medicare. Alma did not pay a higher premium, yet she paid \$5306.80 less in her annual costs than under traditional Medicare. This out-of-

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132. MEDICARE OPTIONS COMPARE, *supra* note 102.

pocket cost difference is primarily due to SmartValue Classic's hospital stay charges. Instead of increasing co-payments based on the length of stay, a SmartValue beneficiary does not pay more than a \$750 charge, which is for the first five days. Beneficiaries with hospital stays shorter than 60 days will only save a moderate amount by selecting SmartValue Classic (\$750, as compared to \$992 deductible under traditional Medicare), but beneficiaries who may face lengthy hospital stays can save significantly. In addition, while SmartValue charges 10% more than traditional Medicare for durable medical equipment and lab service charges, it offers other significant benefits, including lower hospital costs, lower outpatient co-payments, and preventative health care.

Part B co-payments are far less speculative under SmartValue Classic than under traditional Medicare. SmartValue Classic established fixed co-payment amounts, while traditional Medicare charges, a \$131 deductible, plus a percentage of the total cost. SmartValue Classic beneficiaries know their out-of-pocket costs, even before electing to receive care.

#### **SECOND PFFS ALTERNATIVE - HUMANA GOLD CHOICE**

Humana Gold Choice PFFS - \$0 Plan Premium, plan H1804-001, (Gold Choice) is another PFFS plan available to Wisconsin Medicare beneficiaries under MA in 2007.<sup>133</sup> Gold Choice differs from traditional Medicare and SmartValue Classic in that, for certain covered services, it restricts total yearly out-of-pocket expenses of beneficiaries to \$5000.<sup>134</sup> Gold Choice is similar to SmartValue in reduced hospital stay costs and expanded benefits when compared to traditional Medicare, but unlike SmartValue, Gold Choice also offers Medicare Part D prescription drug coverage.<sup>135</sup> All Medicare beneficiaries

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133. Humana, *supra* note 46, at 1, 6.

134. *Id.* at 21.

135. *See id.* at 1.

enrolled in Part A and Part B may apply for Gold Choice, except those with end-stage renal disease and those whose current or former employers help pay for prescription drugs.<sup>136</sup> Beneficiaries pay the Medicare Part B premium but receive additional benefits and coverage without paying an additional premium for Gold Choice.<sup>137</sup> Gold Choice beneficiaries can choose any doctor or health care provider who accepts payment from the PFFS plan.<sup>138</sup> For prescription drug coverage, beneficiaries must use a Humana-network pharmacy.<sup>139</sup>

Gold Choice offers additional benefits not offered by traditional Medicare.<sup>140</sup> The most significant additional benefit is Part D prescription drug coverage at no additional deductible; Gold Choice uses a formulary, or list of drugs covered by the plan.<sup>141</sup> To receive drugs from a network pharmacy, beneficiaries must pay, for a 30-day supply, \$4 for preferred generic drugs, \$30 for preferred brand drugs, \$60 for non-preferred drugs, and a 25% co-payment for specialty drugs when drug costs are under \$2400 for both the plan and the beneficiary.<sup>142</sup> After costs reach \$2400, beneficiaries pay all costs up to \$3850, at which point the catastrophic coverage requires beneficiaries to pay the greater of either: (1) \$2.15 for generic drugs and \$5.35 for all other drugs, or (2) a 5% coinsurance.<sup>143</sup> Gold Choice also offers beneficiaries one physical exam, per year, at a \$15 co-payment cost<sup>144</sup> and one hearing test, every two years, at a \$30 co-payment cost.<sup>145</sup>

Like SmartValue Classic, Gold Choice differs from traditional Medicare in its payment of inpatient care. Gold Choice requires beneficiaries to pay a \$550 co-payment for any

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136. *Id.*

137. *Id.* at 7.

138. *Id.*

139. *Id.* at 1.

140. *Id.* at 7-24.

141. *Id.* at 1-2.

142. *Id.* at 16.

143. *Id.* at 17.

144. *Id.* at 20.

145. *Id.* at 19.

hospital or mental inpatient facility stay.<sup>146</sup> There is no co-payment for additional days, as under traditional Medicare.<sup>147</sup> Gold Choice also differs from traditional Medicare in coverage of skilled nursing facility care.<sup>148</sup> Under traditional Medicare, there are no out-of-pocket costs for days 1-20 and a charge of \$124 for days 21-100; Gold Choice beneficiaries pay \$0 for days 1-3, and \$90 per day for days 4-100.<sup>149</sup>

Gold Choice also differs from traditional Medicare in its outpatient coverage as follows:

- 1) Doctor Office Visits: Beneficiaries pay \$15 for primary care doctor and \$30 for specialist visits. Under traditional Medicare, beneficiaries pay 20% of the cost of each visit.<sup>150</sup>
- 2) Outpatient Surgeries and Services: Instead of paying 20% of the facility charges and doctor charges as under Medicare, beneficiaries pay 20% for a visit to an ambulatory surgical facility and 20% for a visit to an outpatient hospital facility.<sup>151</sup>
- 3) Emergency Care: Beneficiaries pay 20% of the cost, up to \$15, for each visit and coverage is worldwide, with some limitations. Under traditional Medicare coverage, there is no coverage outside of the U.S., except in limited circumstances, and beneficiaries pay 20% of doctor charges and facility charges or a co-payment for each visit if not admitted within three days for the condition.<sup>152</sup>
- 4) Urgently-Needed Care: Beneficiaries pay \$15 for a visit to a primary care physician, \$30 for a visit to a specialist's office, and 20% of the cost for a visit to an outpatient hospital facility or a free-standing outpatient facility. Beneficiaries also have worldwide coverage, with some limitations. Traditional Medicare charges 20%

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146. *Id.* at 8.

147. *Id.*

148. *Id.*

149. *Id.*

150. *Id.* at 10.

151. *Id.* at 11.

152. *Id.* at 11, 23.

of the total costs and does not provide worldwide coverage, except in limited circumstances.<sup>153</sup>

- 5) Outpatient Rehabilitation: Beneficiaries pay \$15 for a visit to a primary care physician, \$30 for a visit to a specialist's office, and 20% of the cost of any other outpatient facility visit, instead of 20% of Medicare-approved amounts.<sup>154</sup>
- 6) Durable Medical Equipment and Prosthetics: Beneficiaries pay 20% of the cost, the same as under traditional Medicare.<sup>155</sup>
- 7) Diagnostic Tests, Lab Services, and X-Rays: For each test, service or x-ray, beneficiaries pay \$15 for services conducted by a primary care physician, \$30 for services conducted by a specialist, and 20% of the cost for services conducted at an outpatient hospital or free-standing facility; under traditional Medicare, beneficiaries do not have a co-payment for lab services but pay 20% of all other services.<sup>156</sup>
- 8) Preventative Treatment: Unlike traditional Medicare where a beneficiary pays 20% in most circumstances, there are no co-payments for diabetic self-monitoring training and supplies, immunizations, colorectal screenings, bone mass screenings, mammograms, prostate screenings, or pelvic exams.<sup>157</sup>

According to CMS Medicare Options Compare, Gold Choice annually costs the average beneficiary of ages 65-69: \$2600 if in very good health (SmartValue - \$2800; Traditional Medicare - \$3200); \$3050 if in good health (SmartValue - \$3550; Traditional Medicare - \$4100); \$3900 if in fair health (SmartValue - \$4500; Traditional Medicare - \$5900); and \$5600 if in poor health (SmartValue - \$7350; Traditional Medicare - \$9000).<sup>158</sup>

Alma Average next chose to participate in the Humana

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153. *Id.* at 12, 23.

154. *Id.* at 12.

155. *Id.* at 13.

156. *Id.*

157. *See id.* at 13-15.

158. MEDICARE OPTIONS COMPARE, *supra* note 102.

Gold Choice PFFS plan. Since her annual income was less than \$80,000, she still must pay the Part B premium of \$93.50 per month, and if she does not require any health services, her annual costs are \$1122.

However, Alma was admitted to the local hospital after breaking her leg and suffering head trauma, and was discharged on day 40. She must pay \$550 for the stay, bringing her yearly cost to \$1672, \$442 less than under traditional Medicare. One week later, Alma stayed for an additional 33 days with pneumonia and incurred an additional \$550. Consequently, her yearly costs total \$2222, compared with \$7074 under traditional Medicare.

In order for Alma to see her primary care physician for a follow-up, she must pay a \$15 co-payment, as opposed to \$40, or 20%, of the \$200 fee under traditional Medicare. She also purchased a \$300 walker, which requires her to pay \$60, or 20% of its cost, the same amount as under traditional Medicare. Under this scenario, Alma's yearly costs with the Humana Gold Choice PFFS plan total to \$2297, as opposed to \$1972 under SmartValue Classic and \$7278.80 under traditional Medicare.

Alma Average's situation shows that out-of-pocket costs are significantly less under Gold Choice than under traditional Medicare. Alma did not pay a higher premium, yet she paid \$4981.80 less in annual costs than she would have under traditional Medicare. Similar to SmartValue Classic, Gold Choice's hospital stay charges were the primary reason for these savings. Instead of increasing co-payments based on the length of stay, Gold Choice beneficiaries pay \$550 per hospital visit. While beneficiaries with hospital stays shorter than 60 days will only save a moderate amount by selecting Gold Choice (\$550, as compared to \$992 deductible under traditional Medicare), beneficiaries facing lengthy hospital stays can save significantly.

Alma's hypothetical situation does not demonstrate the strongest aspect of Gold Choice: prescription drug coverage at no additional cost. While Alma would pay more for Gold Choice coverage than for SmartValue coverage, Gold Choice



may save another beneficiary significant out-of-pocket drug expenses for prescriptions. Furthermore, unlike SmartValue and traditional Medicare, Gold Choice places a cap of \$5000 for total yearly expenses. A beneficiary in fair or poor health will benefit greatly by enrolling in Gold Choice because of the ceiling on total out-of-pocket expenses, the drug coverage, the lower inpatient stay costs, and additional Part B benefits and preventative care.

## CONCLUSION

In the United States, where privatized health insurance pays for the majority of health care services, it is no surprise that the federal government has incorporated privatized alternatives into Medicare, including PFFS plans. PFFS plans are attractive to Medicare beneficiaries because the plans typically have lower out-of-pocket costs and offer other additional benefits. The Alma Average hypothetical case demonstrates how PFFS plans can save beneficiaries significant out-of-pocket costs.

As PFFS plans become increasingly popular, traditional Medicare needs to compete with the PFFS plans while also paying private insurers for PFFS costs and subsidies. The current subsidies, while controversial, are a main reason for PFFS plans' growth. As Medicare + Choice demonstrated, success of privatized Medicare plans relies heavily on continued government funding of the federal subsidies, adequate reimbursement, payment acceptance by health care providers, and beneficiary participation. At present, PFFS plan participation by beneficiaries is growing, as the plans are a viable option for cost-sensitive beneficiaries willing to risk possible plan instability in the future. For those beneficiaries, PFFS plans offer lower out-of-pocket costs and additional benefits, and thus are worth consideration.

**TABLE ONE<sup>1</sup>**

	TRADITIONAL MEDICARE	SMARTVALUE CLASSIC ANTHEM/BCBS	HUMANA GOLD CHOICE
<b>Premium</b>	\$93.50 (2007); \$131 Part B deductible	\$93.50 (2007)	\$93.50 (2007); \$5,000 maximum out-of-pocket expense per year
<b>Inpatient Hospital Care</b>	For each benefit period: Days 1 - 60: \$992 deductible Days 61 - 90: \$248 per day Days 91 - 150: \$496 per lifetime reserve day	Days 1-5: \$150 co- pay per day \$0 co-pay for additional days Must notify plan if planning to be admitted, or have to pay \$50 each day, up to a maximum of \$500 per admission. \$750 out of pocket limit every year. No limit to number of days covered.	\$550 co-pay for each Medicare-covered hospital stay \$0 co-pay for additional hospital days No limit to number of days covered.
<b>npatient SNF Care</b>	Days 1-20: \$0 Days 21-100: \$119 per day	Days 1-20: \$0 Days 21-100: \$25 per day	Days 1-3: \$0 Days 4-100: \$90 per day
<b>Doctor Office Visits</b>	20% coinsurance	\$10 co-pay for each primary care doctor visit. \$10 co-pay for each specialist visit.	\$15 co-pay for each primary care doctor visit. \$30 co-pay for each specialist visit.
<b>Outpatient Surgery and Services</b>	20% of the cost for each ambulatory surgical center visit. 20% of the cost for each outpatient hospital facility visit.	\$100 co-pay for each ambulatory surgical center visit. \$10 to \$100 co-pay for each outpatient hospital facility visit.	20% of the cost for each ambulatory surgical center visit. 20% of the cost for each outpatient hospital facility visit.
<b>Emergency Care</b>	20% of doctor charges and facility charge or co-payment for each visit if beneficiary is not admitted within 3	\$50 for each visit if not admitted within 72 hours for the same condition. Worldwide Coverage.	\$20% of cost, up to \$50, for each visit if not admitted within 72 hours for the same condition. Worldwide Coverage.

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1. *Medicare Options Compare*, *supra* note 102.

	days for condition. No coverage outside U.S.		
<b>Urgently-Needed Care</b>	20% of doctor charges and facility charge or co-pay for each visit if beneficiary is not admitted within 3 days for condition. No coverage outside U.S.	\$50 for each visit if not admitted within 72 hours for the same condition, Worldwide Coverage	\$15 to \$30 for each Medicare-covered urgently needed care visit and 20% of the cost for each visit. Worldwide coverage.
<b>Outpatient Rehabilitation</b>	20% coinsurance	\$10 per visit.	\$30, or 20% of cost per visit.
<b>Durable Medical Equipment</b>	20% coinsurance.	30% of the cost per item. If purchase item that costs more than \$750, you must notify plan, have to pay 70% of bill.	20% of the cost per item.
<b>Diagnostic Tests, X-Rays, and Lab Services</b>	20% coinsurance for diagnostic tests and x-rays \$0 co-pay for lab services	\$0 to \$25 co-pay for clinical/diagnostic lab benefits. \$0 to \$25 co-pay for radiation therapy benefits. \$0 to \$25 co-pay for X-rays.	\$15 to \$30 co-pay (or 20% of the cost) for clinical/diagnostic lab benefits. \$15 to \$30 co-pay (or 20% of the cost) for radiation therapy benefits. \$15 to \$30 co-pay (or 20% of the cost) for X-rays.
<b>Prescription Drugs</b>	Most prescriptions not covered, can still join a prescription drug plan.	Most prescriptions not covered, cannot join a separate Part D plan.	\$4 to \$60 co-pay (or 20% of the cost) of Part B-covered drugs. This plan uses a formulary. \$0 deductible. Pay the following until total yearly drug costs reach \$2400:  <i>Retail Pharmacy</i> \$4 co-pay for a one-month of Preferred Generic drugs \$30 co-pay for a one-month of Preferred Brand drugs \$60 co-pay for a one-month of Other - Non-Preferred drugs

			<p>25% coinsurance for a one-month (30-day) supply of Specialty drugs</p> <p>Gap Coverage: After your total yearly drug costs reach \$2400, you pay 100% until your yearly out-of-pocket drug costs reach \$3850.</p> <p>Catastrophic Coverage: After yearly out-of-pocket drug costs reach \$3850, pay the greater of: \$2.15 co-pay for generic (including brand drugs treated as generic) and \$5.35 co-pay for all other drugs, or 5% coinsurance.</p>
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